MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07857

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months.
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 708 W. Saratoga Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: CECIL HOLLAND ANDREWS, JR.

3.(b) Social Security Number: 215-149699

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

6.(b) Name of husband or wife: Christine Andrews
6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): January 2, 1918

8. AGE: Years	Months	Days	If less than one day
29	8	13	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business:

FATHER
12. Name: Cecil Hollan Andrews, Sr.
13. Birthplace: Virginia

MOTHER
14. Maiden name: Lillian Booker
15. Birthplace: Virginia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/19/47 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location:

18. Funeral director: Leonard Whalen
Address: 1047 Myrtle Ave.

19. 9/15 19 47 (Date rec'd by registrar) Albert R. Franklin Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 15, 19 47, at 4.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 19 47 to Sept., 15 19 47 and that I last saw him alive on September 15, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: Reuben D. Foreman, M. D.
M. D. or other
Address: Henryton, Md. Date signed 9/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

07858

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 10 months, 4 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 4 yrs. 10 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 705 Pennsylvania Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME

BESSIE APPLIN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Edward Applin

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11/3/1884

8. AGE: Years	Months	Days	If less than one day
62	10	21	hrs. min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: James W. Smith
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Louise Boushee
15. Birthplace: North Carolina

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 26 1947 (month) (day) (year)

Cemetery or crematory: Silver Haven Cem.

Location: R. C. Co., Md.

18. Funeral director: Williams Bros. Inc.

Address: 1217 St Paul St

19. Sept 25 19 47 (Date rec'd by registrar) C. Harry Eiser Registrar

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH 9/24 19 47, at 6:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/20/ 19 42, to 9/24 19 47

and that I last saw h 34 alive on 9/23 19 47

Immediate cause of death	DURATION
Coronary Occlusion	4 years
Due to	
Due to	
Other conditions: Hypertensive cardiovascular disease, diabetes mellitus (Include pregnancy within 8 months of death)	5 yrs.

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Berger M.D.
M. D. or other

Address: Sykesville, Maryland Date signed: 9/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07859

47d

CERTIFICATE OF DEATH

Reg. Diat. No. 75

1. PLACE OF DEATH:
County. Carroll
City or town. Rural Westminster 8.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town. Rural Westminster Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. R 3
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lulu Tracey Autz

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife J. Raymond Autz
6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Dec. 8 - 1883

8. AGE: Years	Months	Days	If less than one day
63	9	11	hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name James F. Tracey
13. Birthplace Carroll Co. Md.
MOTHER 14. Maiden name Matilda Campbell
15. Birthplace Carroll Co. Md.
16. Informant Louise P. Edwards
Address Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 23. 1947 (month) (day) (year)
Cemetery or crematory Westminster Cem.
Location Westminster, Md.
18. Funeral director H. Bankard Son
Address Westminster, Md.
19. Sept 20 1947 Wm W. R. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 1947 at 6 30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 30 1947 to Sept 19 1947 and that I last saw h[illegible] alive on Sept 18 1947

Immediate cause of death	DURATION
Generalized Carcinomatosis	
Due to Primary Carcinoma Lung	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation — Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE Joseph E Bush M.D.
M. D. or other
Address Hampstead Md. Date signed 9-19-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07860

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 4 Mo's., 7 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1902 Pennsylvania Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SHIRLEY MAE BLAKE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 5, 1930

8. AGE: Years	Months	Days	If less than one day
17	2	14	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business

FATHER
12. Name: David Lee
13. Birthplace: Pemberton, Va

MOTHER
14. Maiden name: Carrie Blake
15. Birthplace: Baltimore, Md.

16. Informant: Carrie Blake
Address: 1902 Pennsylvania Ave. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-23-47 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Route 30, Md.
18. Funeral director: Wellard A. Jackson
Address: 716 Penna. Ave. Balto.

19. 9/19 (Date rec'd by registrar) 19 47 Albert R. Swanhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19, 1947 at 10.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12, 1946 to Sept., 19, 1947 and that I last saw her alive on September 19, 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 13 1946

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Neulan W. Bonney, M.D.
M. D. or other
Address: Henryton, Md Date signed: 9/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07861

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 11 mos. 15 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 5 yrs. 11 mos. 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: William Bourke

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: 77 | Months: | Days: | If less than one day: hrs. min.

8. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Hospital orderly

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Hospital records
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 26, 1947 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cemetery

Location: Sykesville, Md.

18. Funeral director: C. Harry Owen

Address: Sykesville, Md.

19. Sept. 26 1947 (Date rec'd by registrar) C. Harry Owen Registrar

MEDICAL CERTIFICATION DST

20. DATE OF DEATH: September 18 19 47, at 7:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3 19 41, to September 18 19 47 and that I last saw him alive on September 18 19 47

Immediate cause of death	DURATION
Chronic myocarditis	unk
Due to: Generalized Arteriosclerosis	unkn.
Due to:	
Other conditions: Senile Psychosis, Paranoid type	Six yrs.
Tuberculosis, Pulmonary	3 years.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eibert M.D.
M. D. or other

Address: Sykesville, Maryland Date signed: 9-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

07862

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 11/13/45
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 yr. 11 mos. 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore County
City or town: Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Dogwood Road
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Dennis Eldon Bradley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1/4/29

8. AGE: Years	Months	Days	If less than one day
18	9	16	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Elon Bradley
FATHER 13. Birthplace: Virginia
MOTHER 14. Maiden name: Mildred Higgs
MOTHER 15. Birthplace: Virginia
16. Informant: Records, Springfield State Hospital
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-23-47 (month) (day) (year)
Cemetery or crematory: Hood Shipley Assn.
Location: Mt. Ellicott City, Md.
18. Funeral director: Easton Hoch Funeral Home
Address: Ellicott City, Md.
19. Sept. 20 1947 C. Henry Zile
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/20 1947, at 5:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/13/45 1947, to 9-20 1947 and that I last saw h... im alive on 9-20 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	?
Due to	
Due to	
Other conditions: Psychosis with Mental Deficiency (Include pregnancy within 3 months of death)	Since birth

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M. D. or other
Address: Sykesville, Maryland Date signed: 9/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74 — 07863

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mons. 4 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore-30-
(If outside city or town limits, write RURAL and give nearest town)
Street No. 920 Russell Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
ELOISE BROWN

3. (b) Social Security Number

4. Sex: Female
5. Color or race: Col.
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): January 20, 1930
8. AGE: Years 17 Months 8 Days 7 If less than one day hrs. min.
9. Birthplace Halesburg, Alabama
(Town, county, and state)
10. Usual occupation Scholar
11. Industry or business
FATHER 12. Name Thelmon Brown
13. Birthplace Alabama
MOTHER 14. Maiden name Connie Saunders
15. Birthplace Georgia
16. Informant Deceased
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-1-47 (month) (day) (year)
Cemetery or crematory Mt Lebanon
Location Baltimore 30, Md
18. Funeral director Wyllean A. Jackson
Address 916 Penna. Ave, Balto
19. Sept. 27, 47 (Date rec'd by registrar) Albert R. Grandham Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 19 47 at 8:P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 19 47 to Sept. 27 19 47 and that I last saw her alive on September 27 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4/14/47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Newton W. Moran, M. D.
M. D. or other
Address Henryton, Md. Date signed 9-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

07864

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 61 W. Main St.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 61 W. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah H Clarke

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife Charles M Clarke

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 28 - 1864

8. AGE: Years	Months	Days	If less than one day
82	10	6	..... hrs. ..... min.

9. Birthplace Buffalo, New York (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John R Hazard

13. Birthplace New York

MOTHER 14. Maiden name Jennie Howell

15. Birthplace New York

16. Informant Hazard Clarke

Address Westminster Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 5 - 1947 (month) (day) (year)

Cemetery or crematory Forest Lawn Cem.

Location Buffalo, New York

18. Funeral director D.D. Kartzler & Sons

Address New Windsor & Union Bridge, Maryland

19. 9/4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1947 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1944 to Sept 3 1947 and that I last saw her alive on Sept 2, 1947

Immediate cause of death	DURATION
Coronary disease	abt 4 years
Due to arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C Reese Williams M.D. M. D. or other

Address Westminster Date signed 9/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55a

CERTIFICATE OF DEATH

07865

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Eastview

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Eastview

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: John Conaway

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Maggie O. Conaway

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 5, 1870

8. AGE: Years	Months	Days	If less than one day
76	11	16	hrs. min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)

10. Usual occupation: General store

11. Industry or business

FATHER 12. Name: Zacharias Conaway

13. Birthplace: Maryland

MOTHER 14. Maiden name: Margaret Knight

15. Birthplace: Maryland

16. Informant: Elsie L. Conaway

Address: Eastview, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 9/24/47 (month) (day) (year)

Cemetery or crematory: Deer Park Cemetery

Location: Smallwood, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 9/22 1947 (Date rec'd by registrar) H. Chenoweth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 21 19 47, at 5:3p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 46 to Sept 21 19 47

and that I last saw h..i.M.. alive on Sept 20 - 47 19

Immediate cause of death	DURATION
Carcinoma Glands	
Carcinoma liver	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. E. Jennette M.D.

M. D. or other

Address: 103 E Main Westminster Md. Date signed 9-22-47

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15 2-45-15M

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07866 f

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH

County Carroll

City or town Hampstead Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Hampstead Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Josephine Margaret Czawlytko

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife Paul Peter Czawlytko

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 20, 1900

8. AGE: Years	Months	Days	If less than one day
47	6	29	..... hrs. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name Anthony Jankowak

13. Birthplace Poland

MOTHER 14. Maiden name Mary Agnes Zigrezek

15. Birthplace Poland

16. Informant Paul Peter Czawlytko

Address Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/24/47 (month) (day) (year)

Cemetery or crematory St. Stanislaus

Location Highland town

18. Funeral director Marie E. Fialkowski

Address 1000 S. Kenwood ave.

19. 9/25 19 47 A. W. Kesmodel Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 1947 at 4 20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 15 1947 to Sept 19 1947 and that I last saw h.. alive on September 18 1947

Immediate cause of death Secondary Carcinoma Liver — DURATION ?

Due to Primary Carcinoma Uterus ? —

Due to — —

Other conditions — —

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Jos E. Bush M.D.
M. D. or other

Address Hampstead md Date signed 9-19-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

7867

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 5 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 4 months, 5days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Fannie Bell Derr

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 27, 1888

8. AGE: Years	Months	Days	If less than one day
59	0	17	hrs. min.

9. Birthplace: Union, Pennsylvania (Town, county, and state)

10. Usual occupation: Book seller

11. Industry or business:

FATHER 12. Name: Lewis Krumer Derr

13. Birthplace: Union, Pennsylvenia

MOTHER 14. Maiden name: Mollie Flora Pontius

15. Birthplace: New Cumberland, Pennsylvenia

16. Informant: Hospital records

Address: Springfield State Hospital

17. Transportation & Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 17, 1947 (month) (day) (year)

Cemetery or crematory: Lewisburg

Location: Lewisburg, Pa.

18. Funeral director: William Cook Inc.

Address: 1217-19 Paul St. Balto. Md.

19. Sept 14 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13, 1947, at 10.20p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8, 1947, to September 13 1947 and that I last saw her alive on September 13, 1947

Immediate cause of death	DURATION
coronary occlusion	1 hour
Due to coronary disease, arteriosclerosis and hypertension	about 4 years
Due to	
Other conditions Psychosis with cardio-renal disease	over 1 year

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Irene Hitchman M.D. M. D. or other

Address: Springfield State Hospital Date signed: 9-13-47

07868

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Springfield State Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos., 12 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 7 mos., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Church Home
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Lucy Ellen Dice

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widowed

6.(b) Name of husband or wife: Washington Irving Dice

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 12/22/65

8. AGE:

Years	Months	Days	If less than one day
81	9	8	..... hrs. ..... min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Elias Reed
13. Birthplace: Carroll County, Md.

MOTHER
14. Maiden name: Mary Maltine
15. Birthplace: Carroll County, Md.

16. Informant: Hospital records
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 3 / 1947 (month) (day) (year)

Cemetery or crematory: Pleasant Grove

Location: Sandyville, Md.

18. Funeral director: J. Francis Reed

Address: Westminster, Md.

19. Oct. 1 1947 (Date rec'd by registrar) Harry Hess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30, 1947, at 3 00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 18, 1947, to Sept. 30, 1947, and that I last saw h.. alive on Sept. 30, 1947.

	DURATION
Immediate cause of death: Arteriosclerosis, generalized	?
Due to: Decubitus ulcer over sacrum	2 mos.
Due to:	
Other conditions: Senile psychosis	4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed: 9/30/47

07869

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 b

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 11 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Bowie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Clayton Duckett

3.(b) Social Security Number 717-07-7106

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife Florence Duckett

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) April 19, 1881

8. AGE: Years	Months	Days	If less than one day
66	4	13	hrs. min.

9. Birthplace Charles County, Md. (Town, county, and state)

10. Usual occupation Railroad

11. Industry or business

FATHER 12. Name Augustus Duckett

13. Birthplace Charles Co. Maryland

MOTHER 14. Maiden name Sarah Yates

15. Birthplace Charles Co., Maryland

16. Informant Deceased

Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept 4 1947 (month) (day) (year)

Cemetery or crematory St Mary's

Location Bryan Town, Charles Co. Md

18. Funeral director Clarence Forrest

Address Mitchellville, Md.

19. Sept. 1 1947 (Date rec'd by registrar) Albert R. Swanborne Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1947 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1947 to Sept. 1 1947 and that I last saw him alive on September 1 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben W. Swan, M.D. M. D. or other

Address Henryton, Md. Date signed 9/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

07870

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 76

1. PLACE OF DEATH

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Westminster Rt 3

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret A. Eyler

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Gerald Eyler

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Feb. 27 - 1902

8. AGE: Years	Months	Days	If less than one day
45	6	6	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Stuart Frigell

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Jenny Baker

15. Birthplace Carroll Co. Md.

16. Informant Gerald Eyler

Address Westminster R.D.5. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 5-1947 (month) (day) (year)

Cemetery or crematory Sunpark Mem.

Location Westminster, Md. R.D.

18. Funeral director H.B. Bankard & Son

Address Westminster, Md.

19. 9/4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1947, at 4 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug - 1st 1945, to Sept 3 1947

and that I last saw h.e.r alive on Sept 2 - 1947

Immediate cause of death	DURATION
Carcinoma Uterus	3 yrs?
" Liver	1 yr?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M.D. M. D. or other

Address Westminster Date signed 9-3-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1190

CERTIFICATE OF DEATH

Reg. Dist. No. 8 — 17871

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. Use correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Rural #5
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 4 7

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster (If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural #5 (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Nettie May Fletcher

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan. 10 - 1947
8. AGE: Years | Months: 7 | Days: 26 | If less than one day: hrs. min.
9. Birthplace: Carroll County, Md. (Town, county, and state)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Clinton Fletcher
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elsie M. Samuel
15. Birthplace: Maryland

16. Informant: Mrs. Ellie Fletcher
Address: Westminster, Md. R. D.
17. Burial (Burial, cremation, or removal) Which? Date thereof: Sept. 7-1947 (month) (day) (year)
Cemetery or crematory: Western Chapel Cem.
Location: Westminster Md R. D.
18. Funeral director: H. H. Hartley & Sons
Address: Union Bridge & Westminster, Md
19. Sept 6 47 (Date rec'd by registrar) Emma Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 5 1947 at 7:15 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 5 1947 to Sept 5 1947 and that I last saw her alive on Sept 5 1947

Immediate cause of death	DURATION
acute Cardiac Decompensation	3 hrs
Due to: acute Colitis	3 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thos R Foutz M D (M.D. or other)
Address: Westminster Md Date signed: 9-6-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07872

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 11 mos 28 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch Henryton
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1019 N. Central Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Forbes Jr.

3.(b) Social Security Number: 238-28-8299

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	simgle

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 12, 1920

8. AGE: Years	Months	Days	If less than one day
27	5	12	hrs. min.

9. Birthplace: Grimeslane, N. Carolina
(Town, county, and state)

10. Usual occupation: Defense Work

11. Industry or business:

FATHER
12. Name: Joseph Forbes
13. Birthplace: Grimelane, N. Carolina

MOTHER
14. Maiden name: Edna Wiggins
15. Birthplace: Grimeslane, N. Carolina

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 27 1947 (month) (day) (year)
Cemetery or crematory: Mt Calvery Cem.
Location: Brooklyn Md
18. Funeral director: Chas. Wilson
Address: 1010 Bentley Rd

19. Sept. 24 1947 (Date rec'd by registrar) Albert R. Grandstaff Loc. Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24 1947, at 6:15-PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 26 1944 to Sept. 24 1947 and that I last saw him alive on September 24 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Jan. 1944
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Isaacs, M.D. M. D. or other
Address: Henryton, Md. Date signed: 9/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13C 07873

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ine correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Md. (If outside city of town limits, write RURAL and give nearest town)
How long in above place of death? 27 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Breanch, Henryton (a) If veteran, name war

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville (If outside city or town limits, write RURAL and give nearest town)
Street No. E. Middle Lane (If rural, give LOCATION)

3. (a) FULL NAME: Joseph Thomas Foreman

3. (b) Social Security Number: 220-05-9874

4. Sex: male
5. Color or race: col
6. (a) Single, married, widowed, or divorced: Widowed
6. (b) Name of husband or wife:
6. (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 10, 1911
8. AGE: Years: 36 Months: 4 Days: 11 If less than one day ..... hrs. ..... min.
9. Birthplace: Germantown, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Erna Foreman
13. Birthplace: Maryland
MOTHER 14. Maiden name: Nettie Jackson
15. Birthplace: Maryland
16. Informant: Uncle- Mr. Sam Foreman
Address: E. Middle Lane, Rockville, Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept 23 1947 (month) (day) (year)
Cemetery or crematory: Rocky Hall
Location: Clarksburg Md
18. Funeral director: Dr W Barber
Address: Gaithersville Md
19. September 21 47 (Date rec'd by registrar) Albert R Saunders Local Deputy Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH: September 21 19 47 at 11:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 25 19 47 to September 21 19 47 and that I last saw him alive on September 21 19 47

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Jan. 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben H Foreman, M. D. M. D. or other
Address: Henryton, Md. Date signed 9/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07874

13 1a

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll County
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll County
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 70½ Pennsylvania Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harvey Rutherford Frock

3.(b) Social Security Number: 216-22-1835

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Linnie Keyser Frock
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): August 23, 1877

8. AGE: Years	Months	Days	If less than one day
70		8	hrs. min.

9. Birthplace: Detour, Carroll County, Md.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Farmer

FATHER
12. Name: Isiah Frock
13. Birthplace: Detour, Md.

MOTHER
14. Maiden name: Sarah Whitmore,
15. Birthplace: Rocky Ridge, Md.

16. Informant: Mrs C. W. Dorsey.
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 4, 1947 (month) (day) (year)
Cemetery or crematory: Haugh's Cemetery
Location: Ladiesburg, Md.

18. Funeral director: M. L. Creager & Son
Address: Thurmont, Md.

19. 9/3 (Date rec'd by registrar) 1947 A. K. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1, 1947 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947 to Sept 1 1947 and that I last saw h alive on Aug. 31 1947

Immediate cause of death	DURATION
a. Acute Cardiac Dilatation	5 Minutes
Due to: Chronic myocarditis	2 Yrs
Due to: Chronic Interstitial Nephritis	3 Yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Chas R Foutz M.D. M. D. or other
Address: Westminster Md. Date signed: 9-3-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07875

Reg. Diat. No. 7H

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 6 months, 23 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 5 yrs. 6 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: /

3.(a) FULL NAME: Charlotte H. Gastelle

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Walter Joyce (alias Jaun Gastelle) (deceased) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 3/6/1894

8. AGE:

Years	Months	Days	If less than one day
53	6	20	..... hrs. ..... min.

9. Birthplace: Schenectady, New York (Town, county, and state)

10. Usual occupation: Clerical work

11. Industry or business: Treasury Dept.

FATHER — 12. Name: Unknown

13. Birthplace:

MOTHER — 14. Maiden name: Unknown

15. Birthplace:

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 27 1947 (month) (day) (year)

Cemetery or crematory: Arlington National Cem.

Location: Fort Myer Post Rd. Va.

18. Funeral director: Warren E. Pumphrey

Address: Silver Spring Md.

19. Sept. 28 1947 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH: 9/26 19 47, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/3/42 19 ..... to 9/26 19 47 and that I last saw her alive on 9/26 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	known since 10/46
Due to:	
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other

Address: Sykesville, Maryland Date signed 9/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07876

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 month, 16 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ~~Prince Georges~~ Howard

City or town: Colesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D #2 (Laurel P.O.)

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MARGARET ELIZABETH GIBSON

3.(b) Social Security Number: 220-05-3336

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Charles Gibson

6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): September 10, 1916

8. AGE:

Years	Months	Days	If less than one day
30	11	29	....hrs. ....min.

9. Birthplace: Colesville, Md. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER

12. Name: Dennis Moore, Sr.

13. Birthplace: Maryland

MOTHER

14. Maiden name: Fannie Watkins

15. Birthplace: Maryland

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/11/47 (month) (day) (year)

Cemetery or crematory: Bayne Chapel Cem

Location: Near Laurel, Md.

18. Funeral director: Ridgley Selby

Address: 401 Washington Blvd Laurel, Md

19. 9/8 (Date rec'd by registrar) 19 47 Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 8, 19 47 at 8.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23, 19 47 to Sept. 8, 19 47 and that I last saw her alive on September 8, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Md. Date signed 9/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Authorization to change the County of Residence from 2 or 3 report cards on the Case of tuberculosis in the Bureau of Communicable Diseases; also the in-transfer report which was sent to Dr. Byers, was returned as not being a resident of Prince George's Co. 10-24-47- ams.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07877

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 month, 28 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1610 W. Lanvale Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: THOMAS EDWARD GRAY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 3, 1930

8. AGE: Years	Months	Days	If less than one day
17	5	8	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER
12. Name: Clark Gray
13. Birthplace: New York

MOTHER
14. Maiden name: Florence Rucker
15. Birthplace: Lynchburg, Va.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-15-47 (month) (day) (year)
Cemetery or crematory: Arbutus Mem.
Location:

18. Funeral director: Samuel W. Sullivan Jr.
Address: 1011 N. Arlington Ave

19. 9/11 19 47 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11, 19 47 at 9.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14, 19 47, to Sept. 11, 19 47 and that I last saw him alive on September 11, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Offner, M. D.
M. D. or other
Address: Henryton, Md Date signed: 9/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. Ink or typewriting is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a 07878

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Manchester (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15-7 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Manchester (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clarence Paul Hare

3.(b) Social Security Number 188-16-3559

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W.

6.(b) Name of husband or wife Pearl Hare
6.(c) If alive, give age ..... yeanrs

7. Birth date of deceased (mo., day, yr.) July 3-1880

8. AGE:

Years	Months	Days	If less than one day
67	2	21	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Day Laborer.
11. Industry or business
FATHER 12. Name Jesse Hare
FATHER 13. Birthplace Md
MOTHER 14. Maiden name Eliza J. McComas
MOTHER 15. Birthplace Md
16. Informant Clarence Hare Jr.
Address Millers Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 26/47 (month) (day) (year)
Cemetery or crematory Grave Run
Location Balto co. Md
18. Funeral director Edw C Tipton
Address Hampstead Md
19. Sept. 25 1947 Mrs. W. P. S. Denver (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1947 at 6 A.M. (hour)
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary artery disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Marsh Deputy Medical Examiner M. D. or other
Address Westminster Md Date signed 9/24/47

OC

8251

8251

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

07879

CERTIFICATE OF DEATH

Reg. Diat. No. 70

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 150 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Taneytown, R.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Jonas E. Heltebridle

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Laura Stuller Heltebridle

(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr. 13, 1865

8. AGE: Years: 82 | Months: 5 | Days: 0 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: William Heltebridle

13. Birthplace: Md.

MOTHER — 14. Maiden name: Rebecca Daughtry

15. Birthplace: Md.

16. Informant: Laura Stuller Heltebridle

Address: Taneytown R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 16, 1947 (month) (day) (year)

Cemetery or crematory: Church of God

Location: Uniontown, Md.

18. Funeral director: C.O. Bussard Son

Address: Taneytown, Md.

19. Sept 15 1947 (Date rec'd by registrar) Ethel M. Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13 1947, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1947 to September 13 1947 and that I last saw him alive on September 13 1947

Immediate cause of death: Cerebral Hemorrhage

Due to: Pneumonia, Arteriosclerosis General & myocardial degeneration & Hypertension

Other conditions:

(Include pregnancy within 3 months of death)

DURATION
6/27/47
9/13/47

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. Glenn Speicher M. D. or other

Address: Westminster, Md. Date signed: 9/15/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Pr Specialer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07880

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mos 18 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 507 Greenwillow St.
(If rural, give LOCATION)

(a) If veteran, name war:

3. (a) FULL NAME: Rosa Lee Henderson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 27, 1922

8. AGE: Years: 25 | Months: | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: John Henderson
13. Birthplace: Unkown

MOTHER
14. Maiden name: Elizabeth Clock
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/16/47 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cem.
Location: A. A. County Md.

18. Funeral director: Joseph B. Lockard
Address: 1364 N. Central Ave

19. September 12 47 (Date rec'd by registrar) Albert R. Swanborn Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 12 1947, at 9:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 25 1946, to Sept. 12 1947, and that I last saw her alive on Sept. 12 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug 1 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other

Address: Henryton, Md. Date signed: 9/12/47

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07881

46 f

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 7 months, 7 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 yrs. 7 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5621 Greenhill Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JANE ELIZABETH HICKEY

3.(b) Social Security Number: ***

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12/17/1889

8. AGE: Years	Months	Days	If less than one day
57	9	7	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: William Henry Hickey

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Grace Ann Bailey

15. Birthplace: Maryland

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/27/47 (month) (day) (year)

Cemetery or crematory: Holy Family

Location: Harrisonville, Balto. Co. Md.

18. Funeral director: George W. Little

Address: 2700 Edmondson Ave.

19. 9-26 1947 (Date rec'd by registrar) H. W. Hedrick Registrar

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH: 9/24/47 19 4:10 P m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/17/ 19 45, to 9/24 1947 and that I last saw her alive on 9/24 1947

Immediate cause of death	DURATION
Carcinoma of the liver	6 months
Due to	
Due to	
Other conditions: Psychosis with convulsive disorder epil. clouded state (Include pregnancy within 3 months of death)	since 16 yrs of age

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M. D. or other

Address: Sykesville, Maryland Date signed 9-24-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

07882

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 71 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. Center
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles W. Hughes

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife Hallie J. Hughes
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 29, 1871

8. AGE:

Years	Months	Days	If less than one day
75	11	24	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Machanist; Ret.
11. Industry or business
FATHER 12. Name Samuel Hughes
13. Birthplace Carroll Co. Md.
MOTHER 14. Maiden name Sarah Lookard
15. Birthplace Carroll Co. Md.
16. Informant Mrs. Albert Stone
Address Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 26-1947 (month) (day) (year)
Cemetery or crematory Westminster Cem.
Location Westminster, Md.
18. Funeral director H. Bankard & Son
Address Westminster, Md.
19. 9/24/47 (Date rec'd by registrar) 19.... E. L. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23rd 1947, at 3 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about Sept 15 1937, to Sept 23rd 1947
and that I last saw him alive on Sept 21st 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	Several hours
Due to Cerebral arterio-sclerosis	15 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Z. Billingslea, M.D.
M. D. or other
Address Westminster, Md. Date signed 9-23-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

07883

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos. 14 days
Hospital, institution, or street address where death occurred:
Springfield State Hosp.
How long in hospital or institution? 6 mos. 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 15 Russell Road, Cabin John
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ulysses Grant Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Angie Sayre
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5.31.1864

8. AGE: Years	Months	Days	If less than one day
83	4	11	hrs. min.

9. Birthplace: Marshall County, Iowa
(Town, county, and state)

10. Usual occupation: Real Estate Dealer, Retired

11. Industry or business:

FATHER
12. Name: Issac Johnson
13. Birthplace: ?

MOTHER
14. Maiden name: Alvina Hoberheiser
15. Birthplace: ?

16. Informant: Daughter, Mrs. Evelyne Garthune
Address: 15 Russell Road, Bethesda (14) Md.

17. (Burial, cremation, or removal. Which?) Removal to. Date thereof 9-12-47 (month) (day) (year)
Cemetery or crematory:
Location: Sykesville, Md.

18. Funeral director: Wm. Reuben Lindsay
Address: Bethesda, Md.

19. Sept. 12 1947 (Date rec'd by registrar) C. Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 11 1947 at 10.45P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 1947, to Sept 11 1947 and that I last saw him alive on Sept 10 1947

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions: Senile Psychosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Martin Gross, M.D.
M. D. or other
Address: Springfield State Hosp. Sykesville, Md. Date signed: 9-12-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

07884

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1. PLACE OF DEATH:

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 4 mo 21 da

Hospital, institution, or street address (Where death occurred) Springfield State Hospital

How long in hospital or institution? 1 yr 4 mo 21 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Allegheny

City or town Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie Minerva Jones

3.(b) Social Security Number

4. Sex F

5. Color or race W

6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age 5 years

7. Birth date of deceased (mo., day, yr.) Jan 1st 1883

8. AGE: Years 64 Months 8 Days 28 If less than one day ..... hrs. ..... min.

9. Birthplace Allegheny Co. (Town, county and state)

10. Usual occupation Housewife

11. Industry or business at home

FATHER 12. Name George Jones

13. Birthplace Allegheny Co

MOTHER 14. Maiden name Emma Livingston

15. Birthplace Allegheny Co

16. Informant James Oscar Jones

Address 12 Waverly Terrace Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 3 1947 (month) (day) (year)

Cemetery or crematory Frostburg

Location Allegany Co. Md.

18. Funeral director Jabal Hafer

Address Frostburg, Md.

19. Sept 30 19 47 C. Harry Weed (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1947 at 7-40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 1946 to Sept 29 1947 and that I last saw h.. alive on Sept 29 1947

Immediate cause of death Chronic Hypocardia — DURATION 1 yr

Due to Arterio Sclerosis — 1 yr

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Gaston M.D. M. D. or other

Address Sykesville Md. Date signed 9/29/47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07885

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs. 7 mo's, 3 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Charles
City or town Tampkinsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
WILLIAM FRANCIS KELLY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of huaband or wife Rose Kelly
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 23, 1887

8. AGE: Years	Months	Days	If less than one day
59	10	26	..... hrs. ..... min.

9. Birthplace Charles County, Md.
(Town, county, and state)
10. Usual occupation Farm Laborer
11. Industry or business
FATHER 12. Name John Kelly
13. Birthplace Chaptico, Md.
MOTHER 14. Maiden name Mary Mittleton
15. Birthplace Charles County, Md.
16. Informant Deceased
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 21, 1947 (month) (day) (year)
Cemetery or crematory St. Mary County Md.
Location Maryland
18. Funeral director John T. Stewart Jr.,
Address #30 "H" St. N.E. Wash., D. C.
19. 9/18 (Date rec'd by registrar) 19 47 Albert R. Swanson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18, 1947 at 9.05P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 15, 1943 to Sept., 18, 1947
and that I last saw him alive on September 18, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1942
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W Fuman M.D.
M. D. or other
Address Henryton, Md Date signed 9/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61 07886

Reg. Diat. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester - (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Manchester (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lida K Keyser.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband ~~or wife~~: Howard M Keyser

6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.): Aug 23 - 1875

8. AGE:

Years	Months	Days	If less than one day
72	1	4	....hrs. ....min.

9. Birthplace: Maryland
(Town, County, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Lewis Hauswick
13. Birthplace: Maryland

MOTHER
14. Maiden name: Kate Shaudy
15. Birthplace: Maryland

16. Informant: Howard M. Keyser
Address: Manchester md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 30 47 (month) (day) (year)

Cemetery or crematory: Union Lutheran

Location: Frederick Co. Md

18. Funeral director: Edna Tipton

Address: Hampstead Md

19. Sept. 28th 1947 (Date rec'd by registrar) Mrs. W. R. S. Donner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-27 1947, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1938, to 9-27 1947 and that I last saw h... alive on 9-27 1947

	DURATION
Immediate cause of death: Diabetes Mellitus	12 yrs
Due to:	
Due to:	
Other condition: Coronary artery disease	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Maurice C. Cartwright M. D. or other

Address: Hampstead Md Date signed: 9-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

07887

Reg. Diat. No. (24) 76

I M

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 26 Westmoreland St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Herbert Francis Leatherwood

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Daisy Pearl Harrison

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 24, 1878

8. AGE: Years	Months	Days	If less than one day
68	9	23	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Grocery Sale Mfg. Co.

FATHER — 12. Name: Francis Leatherwood

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Rosa Day

MOTHER — 15. Birthplace: Md.

16. Informant: Mrs John F. Woodcock Jr.

Address: 26 Westmoreland St. Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 20 1947 (month) (day) (year)

Cemetery or crematory: Morgan Chapel Cem.

Location: Mt. Woodbine, Carroll Co. Md.

18. Funeral director: C. Harry Ebaugh

Address: Sykesville, Md.

19. Sept 19 1947 (Date rec'd by registrar) C. Harry Ebaugh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 17 1947 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1947 to Sept 17 1947 and that I last saw him alive on Sept 17 1947

Immediate cause of death	DURATION
Coronary artery disease	years
Due to: Arteriosclerotic C-V disease	years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James T. Monroe M. D. or other

Address: Westminster Md. Date signed 9-18-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07888

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Patapsco
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Patapsco
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Minnie E. Leppo

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Reuben J. Leppo
6.(c) If alive, give age: 86 years

7. Birth date of deceased (mo., day, yr.): April 23, 1862

8. AGE: Years	Months	Days	If less than one day
85	4	21	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Israel Pickett
13. Birthplace: Maryland

MOTHER
14. Maiden name: Susan Fanwell
15. Birthplace: Maryland

16. Informant: Reuben J. Leppo
Address: Patapsco, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 9/16/47 (month) (day) (year)
Cemetery or crematory: Carrollton Church of God
Location: Carrollton, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 9/14 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13 1947, at 11p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20th 1947, to Sept. 13th 1947 and that I last saw h.. alive on Sept. 13th 1947

Immediate cause of death	DURATION
Chronic myocarditis	2 yrs.
Due to	
Due to	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. T. Billingslea M.D.
M. D. or other
Address: Westminster, Md. Date signed 9-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07889 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 adys

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Brandywine

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: GUSSIE MARY MAKLE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: William Makle

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): Auguat 21, 1921

8. AGE:

Years	Months	Days	If less than one day
26	0	19	..... hrs. ..... min.

9. Birthplace: Charles County, Md. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER — 12. Name: James Ford

13. Birthplace: Charles County, Md.

MOTHER — 14. Maiden name: Virgie Gwynfield

15. Birthplace: Charles County, Md.

16. Informant: Patient

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 12 47 (month) (day) (year)

Cemetery or crematory: St Peters

Location: Hadonf Md

18. Funeral director: Nevitt & Ryan

Address: Hadonf Md

19. 9/9 1947 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9, 1947, at 12.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 2, 1947, to Sept. 9, 1947 and that I last saw her alive on September 9, 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: July 1946

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Kaman M.D. M. D. or other

Address: Henryton, Md Date signed: 9/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07890

468

Reg. Diat. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, institution, or street address where death occurred:
153 W. Main
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 153 W. Main
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles F. Manahan

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Ada R. Manahan
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 3 1860

8. AGE: Years	Months	Days	If less than one day
86	10	7	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Farmer. Retired
11. Industry or business

FATHER
12. Name Levi Manahan
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Eliza Baile
15. Birthplace Carroll Co. Md.

16. Informant Miss Maude Manahan
Address 153 W. Main Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 11-1947 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster, Md.

18. Funeral director H Bankard & Son
Address Westminster, Md.

19. 9/10 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8th 19 47, at 2.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18 - 1947 to Sept 8 1947
and that I last saw h-im alive on Sept 8 1947

Immediate cause of death	DURATION
a. Dilatation Cardiac	6 hrs.
Due to b. Carcinoma of Liver	4 Mos
Due to c.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Chas R Fouts MD, M.D. or other
Address Westminster Md Date signed 9-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07891

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 1 day

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 4 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3421 Mondawmin Avenue, Baltimore-16
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: FRANCES MARION MANNING

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6/12/91

8. AGE: Years	Months	Days	If less than one day
56	3	13	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Schoolteacher

11. Industry or business:

FATHER — 12. Name: Francis Marion Manning

13. Birthplace: Baltimore, Maryland

MOTHER — 14. Maiden name: Annie Lee Pindill

15. Birthplace: Anne Arundel County, Maryland

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/27/47 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem.

Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto. 1, Md.

19. 9-26 19 47 (Date rec'd by registrar) Wm. H. Hedrick Registrar

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH: 9/25 19 47 at 7:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/24 19 47 to 9/25 19 47 and that I last saw h... or alive on 9/25 19 47

Immediate cause of death	DURATION
Chronic Nephritis	under
Due to: Hypertension	1½ yrs.
Due to: Diabetes	2 yrs.
Other conditions: Psychosis with cerebral arteriosclerosis	12 yrs?

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D.
M. D. or other

Address: Sykesville, Maryland Date signed: 9/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 07892

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life.

Hospital, institution, or street address where death occurred: N. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Manchester Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: North Main St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Josephine Catherine Maserhiner

3.(b) Social Security Number: 212-16-9923

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William Fredrick Maserhiner

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 14, 1870

8. AGE:

Years	Months	Days	If less than one day
77	4	15	..... hrs. ..... min.

9. Birthplace: Manchester, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Nelson Warehime
13. Birthplace: Maryland

MOTHER
14. Maiden name: Julia Catherine Whiteleather
15. Birthplace: Maryland

16. Informant: Mrs Winifred Houck.
Address: Manchester, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 2 1947 (month) (day) (year)

Cemetery or crematory: Manchester Cemetery

Location: Church St

18. Funeral director: David R Martin

Address: Manchester Md

19. Oct 1 1947 Mrs. W. R. S. Sommer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 29 1947, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18 1944 to September 29 1947 and that I last saw h[illegible] alive on September 25 1947

Immediate cause of death	DURATION
Coronary Occlusion	Suddenly
Due to: Arterio-Sclerotic Cardiovascular	
Due to: Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.: .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... injured at work?

23. SIGNATURE: Joseph E Bush MD
M. D. or other

Address: Hampstead Md Date signed: 9-29-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07893

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos. 28 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sahatorium Colored Branch Henryton

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. 610 9 th. Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Daisy Matthews

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 1, 1927

8. AGE: Years 20 | Months 3 1 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace: Laurel, Md. (Town, county, and atate)

10. Usual occupation: Domestic

11. Industry or business

FATHER — 12. Name: Jerry Ferguson

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Hattie Matthews

15. Birthplace: Maryland

16. Informant: Deceased

Address

17. Burial [illegible] C. (Burial, cremation, or removal. Which?) Date thereof 9/28/47 (month) (day) (year)

Cemetery or crematory

Location Quirkirk Md

18. Funeral director Ridgley Selby

Address Laurel md

19. Sept. 25 19 47 (Date rec'd by registrar) Albert R. Swandham Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 25 19 47 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 19 47 to Sept. 25 19 47 and that I last saw h[illegible]er alive on September 25 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec., 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Reuben D. Kuhn M.D. M. D. or other

Address: Henryton, Md. Date signed: 9/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07894

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 25days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 261 Hoffman St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mc Kenley ~~Mc~~ Mc Lauchlin

3.(b) Social Security Number: 218-07-7409

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Rachel ~~Mc~~ Mc Glauchlin

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): January 31, 1903

8. AGE: Years	Months	Days	If less than one day
44	7	3	..... hrs. ..... min.

9. Birthplace: Laurenburg, N. Carolina
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business:

FATHER
12. Name: George ~~Mc~~ Mc Glauchlin
13. Birthplace: Unknown

MOTHER
14. Maiden name: Lola Mc Neil
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/5/47 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cemetary

Location:

18. Funeral director: Joseph Russ
Address: 1200 McCulloh St

19. Sept. 3 19 47 (Date rec'd by registrar) Albert R. Swandham Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3 19 47 at 11:00 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 19 47 to Sept. 3 19 47 and that I last saw h... im alive on September 3 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Nelson W. Swan, M.D. M. D. or other

Address: Henryton, Md. Date signed: 9-3-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13L 07895

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5yrs. 11mos 22 Days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 509 N. Parrish St
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Gertrude Elizabeth Miller

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 22, 1930

8. AGE: Years	Months	Days	If less than one day
17	5	10	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER — 12. Name: William Miller

13. Birthplace: Annapolis, Maryland

MOTHER — 14. Maiden name: Wyoming Beckett

15. Birthplace: Virginia

16. Informant: Mother- Wyoming Miller

Address: 509 N. Parrish St. Balto. Md.

17. Burial, cremation, or removal. Which? Burial Date thereof 9/5/47 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Balto. Md.

18. Funeral director: Chas. Glodfelter

Address: 510-12 N. Carrollton Ave.

19. September 1 19 47 (Date rec'd by registrar) Albert R. Smallwood Local Deputy Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH: September 1 19 47 at 4:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 10 19 41 to Sept. 1 19 47 and that I last saw her alive on September 1 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1941
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Fuman, M.D.
M. D. or other

Address: Henryton, Md. Date signed: 9/1/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a 07896 81

Reg. Dist. No.

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Carrie E. Minnick

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband ~~or wife~~: Charles O. Minnick
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 3 - 1882

8. AGE: Years: 65 | Months: 3 | Days: 11 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frederick County, Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home

FATHER
12. Name: William W. Fogle
13. Birthplace: Maryland

MOTHER
14. Maiden name: Laura Frome
15. Birthplace: Maryland

16. Informant: Charles O. Minnick
Address: Union Bridge, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 17-47 (month) (day) (year)
Cemetery or crematory: Winters Cemetery
Location: New Windsor R.D. 3 Md
18. Funeral director: H. H. Hartzler & Sons
Address: Union Bridge & New Windsor, Md

19. Sept 15 1947 (Date rec'd by registrar) P. Eidemiller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 14 1947, at 11:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1947, to Sept 14 1947
and that I last saw h...er ...alive on Sept 14 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Case of brain	
Due to: Arterio Sclerosis - Hy B.P.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: J. N. Leppo M. D. or other
Address: Union Bridge Date signed: 9-14-47

VS A15 9.45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61 07897

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster #3

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Westminster #3

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Delia Ann Maelock

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Frank Maelock 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 - 1871

8. AGE: Years	Months	Days	If less than one day hrs.	min.
76	5	21		

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Granville Black

13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Elizabeth Zepp

15. Birthplace Carroll Co. Md.

16. Informant Russell Mitten

Address Westminster #3 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 10. 1947 (month) (day) (year)

Cemetery or crematory Pleasant Valley Cemetery

Location Westminster Md.

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. Sept 10 1947 Margaret Kinglan

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 8 - 1947, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 6 - 1947, to Sept 8 1947

and that I last saw h. alive on Sept 7 - 1947

Immediate cause of death	DURATION
Myocarditis (chr)	
Diabetis (chr)	
Due to Hypertension -	
Nephritis (chr)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M.D. M. D. or other

Address Westminster Md. Date signed 9-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

07898

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years, 2 months, 10 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 8 years, 2 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Baltimore City Hospitals
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: DANIEL MURPHY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3/12/1888

8. AGE: Years	Months	Days	If less than one day
59	5	21	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Fish cleaner
11. Industry or business

FATHER
12. Name: Patrick F. Murphy
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Jane Quinn
15. Birthplace: Maryland

16. Informant: Records, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 6-47 (month) (day) (year)
Cemetery or crematory: Holy Cross Harford Rd
Location: Harford Road
18. Funeral director: Coffman Coop Inc
Address: 1217 St Paul Street
19. Sept 5 19 47 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH: 9/3 19 47 at 10:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/23 19 39 to 9/3 19 47 and that I last saw h im alive on 9/3 19 47

Immediate cause of death	DURATION
Carcinoma of pyloris of stomach	known
Due to:	8/30/47
Due to:	
Other conditions: Psychosis with convulsive disorder, confusional state	8 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M Virginia Beyer M.D.
M. D. or other
Address: Sykesville, Maryland Date signed: 9/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07899

48 ℓ

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Clara E. Norwood

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Norris E. Norwood

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Sept. 29, 1886

8. AGE:

Years	Months	Days	If less than one day
60	11	7	hrs. min.

9. Birthplace: Baltimore City Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Lewis E. King
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary E. Cain
15. Birthplace: Maryland

16. Informant: Mr. Norris E. Norwood
Address: Mt. Airy. Md.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 9-9-47 (month) (day) (year)

Cemetery ~~or crematory~~: Pine Grove

Location: Mt. Airy. Maryland.

18. Funeral director: C. M. Waltz

Address: Winfield Md.

19. Sept. 9 1947 Thos D Snyder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6 1947, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1947 to Sept 6 1947 and that I last saw h~~e~~r alive on Sept 6 1947

Immediate cause of death	DURATION
Carcinoma of Uterus with general Metastasis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. M. Van Poole M. D. ~~or other~~

Address: Mt Airy Md Date signed 9/8/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07900

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 3mos. 10 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1401 Myrtle Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Annie Oldham

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	married

6.(b) Name of husband or wife: Lincoln Oldham

6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): December 15, 1924

8. AGE: Years	Months	Days	If less than one day
22	8	30	....hrs. ....min.

9. Birthplace: Rockhill, S. Carolina
(Town, county, and state)

10. Usual occupation: Waitress

11. Industry or business:

FATHER — 12. Name: George Cathcart

13. Birthplace: Rockhill, S. Carolina

MOTHER — 14. Maiden name: Cynthia Adams

15. Birthplace: Rockhill, S. Carolina

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 16th 47 (month) (day) (year)

Cemetery or crematory: Rockmont M E

Location: M E

18. Funeral director: Elroy O Wilson

Address: 1000 Brantley Ave.

19. Sept. 14 1947 (Date rec'd by registrar) Albert [illegible] Local Deputy Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH: September 14 19 47 at 12:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 19 45 to Sept. 14 19 47 and that I last saw h... or alive on September 14 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 15 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) .... (County) .... (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: Reuben W Foman M.D.
M. D. or other

Address: Henryton, Md. Date signed: 9/14/47

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

07901

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5mos. 19 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Berlin,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Nellie Mae Purnell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 8, 1918

8. AGE: Years	Months	Days	If less than one day
29		12	hrs. min.

9. Birthplace Berlin, Maryland
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER
12. Name John Purnell
13. Birthplace Maryland

MOTHER
14. Maiden name Blanche Didrickson
15. Birthplace Maryland

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 23-47 (month) (day) (year)
Cemetery or crematory Evergreen
Location Berlin, Md. By Express Agent
18. Funeral director James M. Stewart
Address

19. September 20 47 (Date rec'd by registrar) Albert R. Swandner Local Deputy Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH September 20 19 47 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1947 19 47 to Sept. 20 19 47 and that I last saw h... alive on September 20 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W. Fraas, M. D.
M. D. or other
Address Henryton, Md. Date signed 9/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

07902

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster #4
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, Institution, or street address where death occurred: Life
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. Clearfield
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Twin #1 Rimby

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14 - 1947

8. AGE: Years | Months | Days | If less than one day hrs. 30 min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Willard Rimby
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Carrie Dewbiss
15. Birthplace Carroll Co. Md.

16. Informant Mrs. Emily Dewbiss
Address Westminster #4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 16 1947 (month) (day) (year)
Cemetery or crematory Pleasant Grove Cem.
Location Westminster #4, Md.

18. Funeral director H. Bankard Sem
Address Westminster, Md.

19. 9/15 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1947, at 3:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 14 1947, to Sept. 14 1947
and that I last saw him alive on Sept. 14 1947

Immediate cause of death	DURATION
Premature birth	
Due to	
Due to twin birth 9-14-47	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas. R. Foutz M. D. or other
Address Westminster Date signed 9/16/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

07903

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Clearfield RFD 4

(If outside city or town limits, write RURAL, NEAR and give town)

Street address, hospital or institution: Westminster RD 4

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Md County Carroll

City or town Rural Baltimore Ward No.

(If outside city or town limits, write RURAL, NEAR and give town)

Street No. Clearfield

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME No Name (~~Dead~~) Rimbey Twin #2

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Willard Ellsworth Rimbey

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept 14 - 1947

8. AGE: Years | Months: Sept 14 | Days | If less than one day: ____ hrs. 10 min.

9. Birthplace: Carroll (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: Willard Ellsworth Rimbey

13. Birthplace: Mount Airy Maryland

MOTHER

14. Maiden name: Carrie Naples Devilbiss

15. Birthplace: Carroll County

16. Informant: Willard E. Rimbey

Address: Westminster - R.D. 4

17. (Burial, cremation, or removal. Which?) Burial Date thereof 9-16-47 (month) (day) (year)

Cemetery or crematory: Emanuel Church

Location: Mt. Pleasant

18. Funeral director: Bankard & Son

Address: Westminster

19. 9/15 1947 (Date received by registrar) H. Clemson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14th 1947, at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14th 1947 to Sept 14th 1947 and that I last saw him alive on Sept 14th 1947

	DURATION
Immediate cause of death Prematurity.	10 Min.
Due to Riding Down a Rough Road on a Jeep	several days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas R Tout M.D. M. D. or other

Address Westminster Md Date signed 9-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07904

462

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 30 years
Hospital, Institution, or street address where death occurred:
7 Ridge Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7 Ridge Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Laura Catherine Schaeffer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: George E. Schaeffer
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 25, 1867

8. AGE: Years: 80 | Months: 4 | Days: 7 | If less than one day: hrs. min.

9. Birthplace: Silver Run Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: Home - wife

11. Industry or business:

FATHER
12. Name: Jesse Sawyer
13. Birthplace: Carroll Co. Md.

MOTHER
14. Maiden name: Ann Bowman
15. Birthplace: Carroll Co. Md.

16. Informant: Carl L. Schaeffer
Address: Ridge Road, Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 4, 47 (month) (day) (year)
Cemetery or crematory: St. Marys Lutheran Cemetery
Location: Silver Run, Carroll Co. Md.

18. Funeral director: J. E. Myers Jr.
Address: Westminster, Md.

19. 9/3 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 2 19 47, at 11:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30 19 47, to Sept 2 19 47 and that I last saw her alive on September 1 19 47

Immediate cause of death: Anemia with myocardial degeneration — DURATION: 1 year

Due to: Cancer of bowel — DURATION: 1 yr

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reese Wilkens M. D. or other
Address: Westminster Md. Date signed: 9/3/47

07905

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Springfield State Hospital
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? since August 8, 1933

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Mt. Airy, Md.
City or town: Route 6
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rose Lee Spaulding

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1905 March 14

8. AGE: Years	Months	Days	If less than one day
42	5	29	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: John W. Spaulding
13. Birthplace: D.C.

MOTHER
14. Maiden name: Mary Beeraft
15. Birthplace: Md

16. Informant: Brother John W. Spaulding
Address: Mt. Airy, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-17-47 (month) (day) (year)
Cemetery or crematory: Howard Chapel
Location: Lime Corner Md
18. Funeral director: J.O. Kyser & Sons
Address: Everett City, Md

19. Sept 16 1947 (Date rec'd by registrar) C. Harry Ecker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13th 1947, at 7 p.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~September 11~~ 1947, to September 13 1947
and that I last saw h[illegible] alive on September 13 1947

Immediate cause of death	DURATION
Cerebral Thrombosis	Minutes
Due to: Idiopathic hypertension	years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James T. Rhoad Deputy Medical Examiner M. D. or other
Address: Westminster Md Date signed 9/13/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence For the Addition of Name thereon.

G 112 9/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07906

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 120 W. 23rd. Street

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME

MARY ERNESTINE STAMPER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 25, 1931

8. AGE: Years: 16 | Months: 2 | Days: 23 | If less than one day: hrs. min.

9. Birthplace: Nashville, N. C.
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER
12. Name: Benjamin Stamper
13. Birthplace: Nashville, N. C.

MOTHER
14. Maiden name: Myrtle Strickland
15. Birthplace: Nashville, N. C.

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal) Date thereof: Sept 20, 47 (month) (day) (year)

Cemetery or crematory: [illegible] Cemetery

Location: [illegible] AUBURN BALTIMORE

18. Funeral director: [illegible]

Address: 916 Penna. Ave.

19. 9/17 1947 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 17, 1947 at 9.00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 2, 1947 to Sept. 17 1947 and that I last saw her alive on September 17, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 28 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other

Address: Henryton, Md. Date signed: 9/17/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

07907

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:
County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
411 E Baltimore St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 411 E Baltimore St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Ida Starner

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife late Richard C Starner
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 4 - 1871

8. AGE: Years	Months	Days	If less than one day
75	10	4	..... hrs. ..... min.

9. Birthplace Adams County, Penna (Town, county, and state)
10. Usual occupation Seamstress
11. Industry or business

FATHER
12. Name Henry J Williams
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Amanda Hemer
15. Birthplace Pennsylvania

16. Informant Mrs. Amanda W. Bair
Address Taneytown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 11 - 1947 (month) (day) (year)
Cemetery or crematory Mt Union Cemetery
Location Union Bridge, Md R D

18. Funeral director D D Hartzler & Sons
Address New Windsor & Union Bridge, Md

19. June 9. 19 47 Ethel M Mehrling Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION E.S.T.

20. DATE OF DEATH September 8 19 47 at 345 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 19 47 to Sept 8 19 47
and that I last saw her alive on Sept 8 19 47

	DURATION
Immediate cause of death Cardiac and respiratory failure	
Due to Cerebral hemorrhage	3 days
Due to Arter. Hypertension	? years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. P. Bradley M. M. D. or other
Address Taneytown, Md. Date signed 9-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07908

83a

CERTIFICATE OF DEATH

Reg. Diat. No. 80

1. PLACE OF DEATH:
County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Rural
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Hannah May Stem

3.(b) Social Security Number None

4. Sex: female | 5. Color or race: white | 6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband ~~or wife~~: C Edward Stem

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 23 - 1871

8. AGE: Years 76 | Months 4 | Days 18 | If less than one day: hrs. min.

9. Birthplace: Frederick County, Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: George W Hurlbrink
13. Birthplace: Maryland

MOTHER
14. Maiden name: Kitty Baile
15. Birthplace: Maryland

16. Informant: C Edward Stem
Address: New Windsor Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Sept 13-47 (month) (day) (year)
Cemetery or crematory: Bethel Cemetery
Location: Sams Creek Md

18. Funeral director: H. H. Hartlett & Sons
Address: Union Bridge New Windsor Md

19. Sept-13. 47 (Date rec'd by registrar) Emt Budd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 10 1947, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1947 to Sept 10 1947 and that I last saw her alive on Sept 10 1947

Immediate cause of death: Ex Location Duration: Dec 6-
Due to: Cerebral Hemorrhage
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE J. N. Legg M. D. or other
Address Union Bridge Date signed 9-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07999

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mons. 5 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or institution? 8 mons. 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Girdletree

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: HATTIE STEVENSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: James Stevenson

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): July 18, 1890

8. AGE: Years	Months	Days	If less than one day
57	2	7	..... hrs. ..... min.

9. Birthplace: Girdletree (Worcester) Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Isaac Collick

FATHER — 13. Birthplace: Girdletree, Maryland

MOTHER — 14. Maiden name: Elizabeth Bishop

MOTHER — 15. Birthplace: Girdletree, Md.

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-28-47 (month) (day) (year)

Cemetery or crematory: Coal Spring

Location: Girdle Tree Md.

18. Funeral director: Clay Dennis

Address: Snow Hill, Md.

19. Sept. 25 47 (Date rec'd by registrar) Albert R. Smullen Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 25 19 47 at 9: P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 20 19 47 to Sept. 25 19 47 and that I last saw her alive on September 25 19 47

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Oct. 1 1946

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Shreve, M.D. M. D. or other

Address: Henryton, Md. Date signed: 9/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

50

0791079

Reg. Dist. No. 1944

M

1. PLACE OF DEATH:
County Frederick CARROLL
City or town Detour- rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick Carroll
City or town Detour
(If outside city or town limits, write RURAL and give nearest town)
Street No. --
(If rural, give LOCATION)
2.(a) If veteran, name war --

3.(a) FULL NAME: Lorena Loretta Troxell

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: Lester D. Troxell
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): August 26, 1886

8. AGE: Years	Months	Days	If less than one day
61		13	hrs. min.

9. Birthplace: Rocky Ridge, Frederick Co. Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Albert Valentine.
13. Birthplace: Detour, Md.

MOTHER
14. Maiden name: Martha E. Fox
15. Birthplace: Detour, Md.

16. Informant: Mr. Lester D. Troxell
Address: Detour, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 12, 1947 (month) (day) (year)
Cemetery or crematory: Rocky Ridge Mt. Tabor.
Location: Rocky Ridge, Md.

18. Funeral director: M. L. Creager & Son
Address: Thurmont, Md.

19. Sept. 11, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9, 1947 at 4:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2, 1947, to September 9, 1947, and that I last saw h.. alive on September 5, 1947.

	DURATION
Immediate cause of death: Carcinomatosis	?
Due to: Primary site: Left Breast 10/23/47 - A.S.	
Due to:	
Other conditions: myocarditis, chronic	?

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: M. Franklin Bixby M. D. or other
Address: Thurmont Md. Date signed: Sept. 10 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 13b 07311 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 1/21/30

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 17 yrs., 8 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4509 Kathland Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ROBERT WITMER WALTZ

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	WIDOWER

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4/1/1877

8. AGE: Years	Months	Days	If less than one day
70	5	24	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business:

FATHER
12. Name: Jacob Waltz
13. Birthplace: Maryland (Baltimore)

MOTHER
14. Maiden name: Katherine N. Pope
15. Birthplace: Maryland (Baltimore)

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/27/47 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

16. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 9-26-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/25 19 47 at 4:00 A.M. (dst)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/11 19 43 to 9/25 19 47 and that I last saw h... alive on 9/25 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 yrs.
Due to:	
Due to:	
Other conditions: Manic Depressive Psychosis, depressed phase 17 yrs. (Include pregnancy within 3 months of death)	

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D
M. D. or other

Address: Sykesville, Maryland Date signed: 9/25/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

07312

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 12 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 mos., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ------

City or town: Baltimore - 30
(If outside city or town limits, write RURAL and give nearest town)

Street No. 323 Scott St.,
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: LAVINA WEAVER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Theodore Griffith

6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): July 20, 1869

8. AGE: Years	Months	Days	If less than one day
78	1	25	....hrs. ....min.

9. Birthplace: Lancaster, Pa.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: own home

FATHER — 12. Name: Hospital records John Weaver

13. Birthplace: Lancaster, Pa.

MOTHER — 14. Maiden name: Anna Dussinger

15. Birthplace: Lancaster Pa.

16. Informant: Hospital records Lloyd Griffith

Address: 323 Scott st.

17. Burial (Burial, cremation, or removal, which?) Date thereof 9-17-47 (month) (day) (year)

Cemetery or crematory: St. Peters Lutheran Cemetery

Location: Sykesville Penn.

18. Funeral director: Charles W. Lockwood

Address: 703 McHenry St.

19 9-16 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14 19 47, at 12:20 P. M. D.S.T.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 19 47, to Sept. 14 19 47 and that I last saw her alive on September 14 19 47

Immediate cause of death	DURATION
Cerebral Hemmorrhage	3 days
Due to: Cerebral Arteriosclerosis	----
Due to:	
Other conditions: Senile Psychosis (Include pregnancy within 3 months of death)	several months

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other

Address: S.S.H., Sykesville, Md. Date signed 9-14-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07913

Reg. Dist. No. 406 1976

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution or street address where death occurred:
135 E. Main
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 135 E. Main
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edmund Harris Weller

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Maude B. Lawyer
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13 — 1870

8. AGE: Years 76 | Months 11 | Days 15 | If less than one day ... hrs. ... min.

9. Birthplace Uniontown, Md.
(Town, county, and state)

10. Usual occupation Barber

11. Industry or business Own shop

FATHER
12. Name James C. Weller
13. Birthplace Thurmont, Md.

MOTHER
14. Maiden name Virginia C. Harris
15. Birthplace Virginia

16. Informant Ruth E. Weller
Address 135 E. Main, Westminster, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 22. 1947 (month) (day) (year)
Cemetery or crematory Prospect Hill Cemetery
Location Taneytown, Md.

18. Funeral director H B Bankard & Son
Address Westminster, Md

19. 9/19 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18-47 19... at 11:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10th 1947, to Sept. 18th 1947 and that I last saw him alive on Sept. 18th 1947

Immediate cause of death	DURATION
Carcinoma of stomach	9 mos.
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. T. Billingslea, M.D.
M. D. or other
Address Westminster, Md. Date signed 9-19-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


SEP 22 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07914

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mos. 6 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 614 W. Mulberry
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph White Jr.

3.(b) Social Security Number: 220-14-7057

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 9, 1926

8. AGE: Years	Months	Days	If less than one day
21	3	25	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Joe White

13. Birthplace: Norfolk, Virginia

MOTHER — 14. Maiden name: Mary Jackson

15. Birthplace: Shiloh, Virginia

16. Informant: Deceased

Address:

17. (Burial, cremation, or removal? Which?) Date thereof: Sept 5 47
(month) (day) (year)

Cemetery or crematory: Balto City Morgue, Baltimore Md.

Location: Baltimore City Md.

18. Funeral director: Mrs. Frances A. Hensley

Address: 578 W. Biddle st.

19. Sept. 4 1947 (Date rec'd by registrar) Albert R. Swankhorn Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 6 1947, at 2:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 1947 to Sept 4 1947 and that I last saw him alive on September 4 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan, M.D.
M. D. or other

Address: Henryton, Md. Date signed: 9/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

07915

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Louisville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Louisville
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. Finksburg
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: EMMA B. WYATT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Carlton B. Wyatt
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1880

8. AGE: Years 66 | Months 11 | Days 18 | If less than one day: hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: August Kohlheim
13. Birthplace: Germany

MOTHER
14. Maiden name: Bertha Malchow
15. Birthplace: Germany

16. Informant: Mr. C.B.Wyatt
Address: Finksburg, Md.

17. Burial (Burial, ~~cremation, entombment~~. Which?) Date thereof 9-15-47 (month) (day) (year)
Cemetery ~~or crematory~~: Mini
Location: Princess Ann, Somerset Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. 9/13 (Date rec'd by registrar) 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 12, 1947, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 20, 1947, to Sept. 12, 1947 and that I last saw her alive on Sept. 12, 1947

Immediate cause of death	DURATION
Coronary thrombosis	1 day
Due to: Cardio Vascular Dis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. E. Martin, M. D. or other
Address: Randallstown, Md. Date signed: 9/13/47